STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445130	A. BUILDING _____ B. WING _____	08/19/2010

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NHC HEALTHCARE, SPARTA	34 GRACEY ST SPARTA, TN 38583

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F 000	INITIAL COMMENTS An annual recertification survey and complaint investigations #24540 and #25775 were completed at NHC Healthcare of Sparta on August 17-19, 2010. No deficiencies were cited related to the complaint investigations under 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000	This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings not the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the score and severity regarding any of the deficiencies cited are correctly applied.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure one resident (#1) of twenty two residents remained restraint free. The findings included: Resident #1 was admitted to the facility on October 21, 2004, with diagnoses including Alzheimer's Disease, Anxiety, and Aphasia. Medical record review of a Physical Restraints RAP Narrative dated March 22, 2010, revealed "Resident will use side rail on left side of bed to pull and hold to." Medical record review of the comprehensive care plan dated May 6, 2010, revealed "...risk for falls...I have a history of attempting transfer unassisted...Assist me with my current task when I am attempting to transfer unassisted." Medical record review of the certified nurse assistant Patient Specific	F 221	**F 221 Right to be Free from Physical Restraints** On 8-18-10 one side rail was released on resident #1 so that only the side rail on the left side of the bed was up. All documentation was changed to reflect that one side rail on the left side of the bed will be used by the resident to pull and hold to. On 9-2-10 all residents were reviewed to verify that care plans matched what was being done as related to side rails. Director of Nursing conducted in-service training for all nursing staff on 9-6-10 regarding proper use of side rails. Completed 9-6-10 The Director of Nursing will monitor compliance of right to be free from physical restraints through the quality assurance process. All residents with Side rails will be reviewed weekly x 8 weeks by the Director of Nursing or Unit Manager.	9-6-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] Administrator 9-3-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 Information revealed, "...siderails...x1 (times one) to left side-fall risk." Medical record review of the quarterly minimun data set (MDS) dated June 15, 2010, revealed no side rail of any type in use. Observation on August 18, 2010, at 7:30 a.m., revealed resident in bed with full side rails up on both sides of the bed. Interview on August 18, 2010 at 9:30 a.m., with the 300 Unit Manager revealed only one side rail should be up on the back (left side) of the resident's bed.	F 221	**F 221 cont.** Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse. After 8 weeks, the monitor will continue as directed by the QA committee.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a comfortable shower room for one shower room (unit 3) of three units in the facility. The findings included: Observation on August 19, 2010, at 9:00 a.m., in the unit 3 shower room revealed Certified Nurse Assistant (CNA) #1 assisted resident #6 with a shower. Observation revealed the room had no source of heat and the room was cool with cold	F 246	**F 246 Reasonable Accommodation of Needs/Preferences** On 9-1-10 two "hotpod" in-line electric duct furnace systems were ordered to be installed in the shower rooms. These units are controlled by an individual thermostat to allow temperatures to be adjusted per the resident's wishes. Contractor will install on 9-8-10. On 9-8-10 all staff were inserviced by the Administrator on how to use these devices. Completed 9-8-10 The Administrator will monitor compliance of reasonable accommodation of needs/preferences through the quality assurance process. The Administrator will interview both residents and staff weekly x 4 then monthly x 3 months to determine if temperature in the shower rooms were at a comfortable setting.	9-8-10

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F 246	Continued From page 2 air flowing from the vent in the ceiling, the resident complained frequently of being "cold", and the resident's hands and feet were a light blue color. Interview on August 19, 2010, at 9:05 a.m., with CNA #1 confirmed the shower room was cool with the cold air flowing from the ceiling vent; the staff had no means of warming the room for the resident's comfort; and the staff "just tries to hurry." Interview on August 19, 2010, at 10:15 a.m., in the conference room with the administrator confirmed the shower room on unit 3 was cool with the air conditioning in use and no source of heat for residents comfort during a shower.	F 246	**F 246 cont.** Findings of the quality assurance monitor will be reported by the Administrator to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse. After 4 months, the monitor will continue as directed by the QA committee.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide medically related social services needed for two residents (#4 & #16) of twenty-two residents reviewed. The findings included: Resident #4 was readmitted to the facility on January 11, 2010, with diagnoses including	F 250	**F250 Provision of Medically Related Social Service** On 8-18-10 resident # 4 was seen by LCSW. On 8-19-10 resident #4 was seen by psych nurse practitioner. Both will continue to see resident as resident desires. Resident #4 has a discharge plan of care that includes notification to Choices Coordinator/AAAD to assist with placement options. On 9-1-10, social worker contacted resident's #4 Choices Coordinator to advise her of resident's desire to return to the community. On 9-3-10 all PHQ9/PHQ9-OV forms were reviewed by social service the department. Those residents who were identified for potential depression were reported to the responsible clinician for intervention. Residents will be assessed on admission, through the MDS process, per staff reports and during interdisciplinary team meetings for expression of returning to the community.	9-6-10

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F 250	Continued From page 3 Cerebral Vascular Accident (CVA), Depression and Anxiety. Medical record review of the MDS (Minimum Data Set) dated July 7, 2010, revealed the resident had a short term memory problem and had modified independence for decision making. Medical record review revealed the resident had received Speech Therapy from readmission, had a Modified Barium Swallow Study on June 10, 2010, and afterwards had the diet upgraded to Mechanical Soft with chopped meat, no straws. Medical record review of the physician's progress note of August 5, 2010, revealed, "...resident wanting PEG (percutaneous feeding tube) removed..." Medical record review of the physician's orders revealed the supplemental tube feedings were discontinued on August 6, 2010. Medical record review of the social services notes dated August 12, 2010, revealed "Pt. will be staying long term...unable to go home because friends state...no where to go." Observation and interview of the resident at 1:30 p.m., in the resident's room on August 18, 2010, revealed the resident had finished eating lunch in bed. Interview revealed the resident was reluctant to be interviewed, but the resident verified a plan to eventually leave the nursing home and stated, "First, I need to get this tube out...I don't know how it got there..." Interview with the social services assistant (SSA) verified resident #4 would not be able to return to previous home due to it being sold. Interview revealed the SSA stated the resident was	F 250	**F 250 cont.** A resident who expresses the goal to return to the community will have transition planning coordinated by the interdisciplinary team support system and Choices/AAAD ongoing. On 9-6-10 all staff were inserviced by the Administrator on how to initiate the transition process. Completed 9-6-10 Resident #16 has been offered mental health services to address indicators of "feeling down, depressed or hopeless" as identified by the PHQ-9. Resident has received one on one support visits from center staff to encourage expression of mood and seek interventions keeping in mind the patients right to refuse mental health services/staff interactions. Physician was notified on 8-18-10 of indicators. All residents will be identified for potential depression symptoms through the PHQ9/PHQ9-OV and staff observations. Symptoms will be communicated to responsible clinician for consideration by 9-3-10. Residents who display or have identified mood indicators will have symptoms communicated to responsible clinician. On 9-6-10 all staff were inserviced by the Administrator on communicating symptoms to the responsible clinician and the clinician responsibility upon receiving the information. Completed 9-6-10	

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F 250	Continued From page 4 followed by "a psych nurse" and a licensed counselor/social worker (LCSW). Interview verified the SSA had not spoke with the resident, LCSW, or the psych nurse since the information in the social services note of August 12, 2010, was given to the SSA by the resident's friend. During interview, the SSA stated the psych nurse mainly saw the residents for medication needs and the SSA stated it was not unusual the psych NP (nurse practitioner) had not seen the resident since June 17, 2010. Interview confirmed the SSA was unaware of the NP'S plan in June that stated the resident would only be seen PRN (as needed) in the future. Interview confirmed the SSA had not been aware the LCSW (consulting with the resident for counseling needs) had not seen the resident since May 2010. Interview with the Admissions Coordinator/Social Worker on August 18, 2010, at 9:30 a.m., in the conference room, revealed the LCSW was not seeing the resident. Interview confirmed this was an oversight. During interview, the Admissions Coordinator/Social Worker confirmed the SSA had not shared the information related to the resident's house being sold and stated, "(SSA's name) doesn't share everything with me." Interview with the Administrator, in the conference room at 4:50 p.m., on August 18, 2010, verified the resident had a lack of an effective family/support system and a continued need for emotional support and stated "...(resident) needs to continue with psych services." Medical record review revealed resident #16 was a sixty-two year old, admitted to the facility on July	F 250	**F 250 Cont.** The Director of Social Services will monitor compliance of provision of medically related social service through the quality assurance process. The Director of Social Services will monitor patients who have expressed a goal of returning to the community to verify transition planning is reflected in the care plan and documentation of the planning process is reflected in the medical record. The Director of Social Services will also monitor patients who have reportable PHQ9-PHQ9-OV severity score and verify that this has been reported to the responsible clinician. The Director of Nursing will monitor that the clinician has reported findings to the Doctor. Monitors will be done monthly x 3 months and findings of the quality assurance monitor will be reported by the Director of Social Services and Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse. After 3 months, the monitor will continue as directed by the QA committee.	

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F 250	Continued From page 5 22, 2010, following a Hemicolectomy for Ischemic Bowel with creation of an Ileostomy, and the post-op complication of an Abdominal Wound Infection. Medical record review revealed the resident had a poor history of any medical care and additional diagnoses included a history of Alcohol Abuse with Cirrhosis of the Liver, Portal Hypertension, Ascites, Uncontrolled Diabetes with Neurological Manifestations, and Chronic Back Pain. Medical record review of the Physical Therapy note from August 9, 2010, revealed, "...surgery for ischemic bowel, also requiring colostomy and ileostomy. Now both ostomies are infected, with necrotic tissue present that needs selective debridement..." Review of the MDS (Minimum Data Set) dated August 1, 2010, revealed the resident had insomnia and a deteriorated mood assessed, was unable to ambulate, and had daily moderate pain. Review of the "Resident Mood Interview" completed by the Social Worker Assistant (SSA) on August 2, 2010, revealed the resident was, "feeling down, depressed, or hopeless for two to six days" and the total score of the "Mood Interview" tool was "4." Review of the physician orders revealed no consults for the Psych Nurse Practitioner or the Licensed Counselor/Social Worker. Interview with the Admissions Coordinator/Social Worker on August 18, 2010, at 9:30 a.m., in the conference room, revealed the Social Worker stated consults with the LCSW and the Psych NP were the facility's method used to address residents who experienced medically related social issues such as an inability to cope with loss	F 250		

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F 250	Continued From page 6 of previous body functions, chronic pain, depression, and/or were in need of emotional support. Interview with resident #16's physician, on August 19, 2010, at 11:10 a.m., by telephone, verified the facility's staff had not spoke with the physician about the resident having medically related social services needs prior to August 18, 2010. Interview revealed the physician stated the resident had not wanted to see anyone from psych services when the physician had previously brought up the subject with the resident. Observation and interview of the resident on August 19, 2010, at 1:50 p.m., revealed the resident in the bed, lying on back. During interview, resident #16 was asked about willingness to be seen by a Psych Nurse Practitioner or a counseling Social Worker to have someone to talk with and the resident stated, "No....I don't believe in psychiatrist...I just need to be able to stand on my feet and walk..." Interview with the Administrator on August 19, 2010, at 2:10 p.m., in the conference room, verified the SSA does not proceed with a referral to psych services or the LCSW unless a resident scores a "5" or above on the "Resident Mood Interview." During the interview, the Administrator verified the interview tool had limitations and confirmed the SSA had not included the resident's loss of function (with the need for ileostomy), the chronic disabling medical condition, and chronic pain when assessing resident #16's need for referral to the Psych NP and/or the LCSW. Interview revealed the Administrator had entered into a conversation with the resident's girlfriend on	F 250		

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F 250	Continued From page 7 August 18, 2010, related to the continued chronic pain the resident was experiencing. Interview with the Administrator continued and revealed neither the Administrator or the Admissions Coordinator/Social Worker had spoken with the resident prior to the order for a psych consult being obtained on August 18, 2010.	F 250	**F253 Housekeeping and Maintenance Services** On 9-3 all air condition covering and vents were cleaned by the maintenance department. On 9-3 all fans were cleaned by the maintenance department. All over the bed tables were cleaned through out the facility by the housekeeping staff beginning 8-19-10. Beginning 8-19-10 all feeding tube poles were cleaned by the nursing staff. On 9-2 a schedule was developed to make sure all items listed are maintained. On 9-6-10 all staff were inserviced by the Administrator about keeping these items clean. Completed 9-6-10 The Housekeeping Supervisor, will monitor the air conditioner covers and the over the bed tables, Maintenance Director will monitor air conditioner vents and fans and the Director of Nursing will monitor the feeding tube poles for compliance of housekeeping and maintenance services. The Housekeeping Supervisor, Maintenance Director and Director of Nursing will conduct a visual review at least weekly x 8 weeks to assure items are clean. Findings of the quality assurance monitor will be reported by the Housekeeping Supervisor, Maintenance Director and Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse. After 8 weeks, the monitor will continue as directed by the QA committee.	9-6-10
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a clean environment during the initial tour of the facility. The findings included: Observation during the initial tour of the facility on August 19, 2010, at 9:00 a.m., in the presence of maintenance staff, the following was revealed: 1. Air conditioner covering and vent dirty in room 210. 2. Personal fan dusty in room 223. 3. Over the bed tables soiled with dried substance in rooms 222, 223, 305, 317. 4. Feeding tube pole with dried substance on the pole bases in room 105 and room 218. Interview with the maintenance staff on August 19, 2010, at 9:30 a.m., confirmed the facility failed to maintain a clean resident environment.	F 253		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 8 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for one (#17) resident's AICD (automatic implantable cardio-defibrillator) of twenty-two residents reviewed. The findings included: Resident #17 was admitted to the facility on July 15, 2010, with diagnoses including Chronic Atrial Fibrillation with Coumadin Therapy, Coronary Artery Disease with a history of Coronary Artery Bypass Grafts, three Acute Myocardial	F 279	**F 279 Develop Comprehensive Care Plans** On 8-27-10 resident #17 was discharged from the facility. All residents were reviewed on 9-2-10 to determine if any other residents had an AICD, there are none at this time. On 9-6-10 nursing staff was inserviced by the Director of Nursing on how to care plan for a patient with a AICD to include any safety precautions that need to be taken. Completed 9-6-10 The Director of Nursing will monitor compliance of comprehensive care plans through the quality assurance process. New admissions will be reviewed by the Director of Nursing or Unit Manager to assure that the care plan for a resident with AICD, listed in their history or physical, includes any type of safety precautions that are needed this will continue on a on going basis. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	9-6-10

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F 279	Continued From page 9 Infarctions, and Arrhythmias. Medical record review of the resident's diagnoses listed by the nursing staff and on the physician's history and physical revealed "defibrillator" listed. Observation and interview with the resident on August 17, 2010, in the resident's room at 9:40 a.m., revealed the resident was alert, oriented, and able to converse and share recent medical history. Observation of the resident at 9:20 a.m., on August 19, 2010, revealed the resident up in the hall ambulating independently with a walker. Interview with LPN #1 on August 19, 2010, at 9:10 a.m., at the Station 1 nursing desk verified the resident's chart was not marked with an alert for the presence of an AICD. Interview confirmed LPN #1 had not previously been aware the resident had an implanted defibrillator. Interview confirmed the medical record did not define safety precautions due to the presence of the AICD and did not define whether the AICD included a pacemaker. Medical record review of the care plan with LPN #1 verified the AICD was not included in the resident's plan of care. Interview with LPN #1 at 10:00 a.m., on August 19, 2010, in the conference room, revealed the resident's cardiologist had been contacted within the last hour and LPN #1 was informed the resident had an appointment to see the heart doctor in September to have the AICD and pacemaker checked. During interview, LPN #1 stated the facility didn't have a defined procedure or protocol to address residents with an AICD and the LPN confirmed the assessment and care planning of the resident by the nursing staff had not included the AICD.	F 279		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=D	Continued From page 10 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post the daily staffing in a prominent place, in a clear and readable format.	F 356	**F 356 Posted Nurse Staffing** On 9-2-10 the daily staffing was posted on each of the three nursing stations in a prominent place. On 9-6-10 the Director of Nursing inserviced all staff on the locations of the posted nurse staffing. Completed 9-6-10 The Director of Nursing will monitor compliance of posted nurse staffing through the quality assurance process. The Director of Nursing, Nursing Secretary or Nursing Supervisor will verify the current staffing pattern is posted daily x 8 weeks. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	9-6-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445130	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SPARTA	34 GRACEY ST SPARTA, TN 38583

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F 356	Continued From page 11 The findings included: Observation on August 17, 2010, from 9:15 a.m., to 4:30 p.m., August 18, 2010, from 7:15 a.m., to 5:15 p.m., and on August 19, 2010, from 7:15 a.m., to 8:45 a.m., of the three main entrances to the facility revealed no posting of the daily staffing for the facility's three units. Interview on August 18, 2010, at 8:50 a.m., in the conference room with the administrator, revealed the administrator was unsure where the staffing was posted but believed it was on station 2. Observation and interview on August 19, 2010, at 8:55 a.m., with the administrator and the director of nursing on station 2 revealed a white piece of paper with the staffing printed, in a clear plastic sleeve taped to the medication room window. Interview with the administrator and the director of nursing at the time of the observation confirmed the public could not easily find and read the staffing posted on the medication room window.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	**F 371 Food Procure, Store/Prepare/Serve - Sanitary** On 8-19-10 the Dietary Manager and designee cleaned the heavy dark substance build up on the dish rack caddy in the dishroom, cleaned the dark substance around the opening of the ice machine, cleaned the food spillage in the reach in cooler, cleaned the dried food spillage on the condiment cart, cleaned the grease and dust buildup on the exhaust hood and the grease and dust buildup between the convection oven and the range.	9-6-10

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F 371	Continued From page 12 by: Based on observation and interview the facility failed to store, prepare and serve food under sanitary conditions in the main kitchen and on the 300 unit. The findings included: The following observations were made in the kitchen on August 18, 2010, at 11:00 a.m.: 1. Heavy dark substance build up on the dish rack caddy in the dishroom. 2. Dark substance around the opening of the ice machine. 3. Food Spillage in the reach in cooler. 4. Dried food spillage around the base of the steam table. 5. Dried food spillage on the condiment cart. 6. Grease and dust buildup on the exaust hood. 7. Grease and dust buildup between the convection oven and the range. Continued observation at 11:22 a.m., during the noon meal service on the 300 unit revealed the following: 1. Regular cottage cheese served at 49 degrees. 2. Pureed cottage cheese served at 54 degrees. 3. Mixed fruit served at 54 degrees. Interview with the dietary manager on August 18, 2010, at 2:00 p.m., confirmed the cold food was not served at the proper temperature of 40 degrees and that areas of the kitchen were not clean. Observation on August 17, 2010, at 9:35 a.m., of	F 371	**F 371 cont.** On 9-2-10 the Regional Dietary Consultant along with the Dietary Manager completed a sanitation check of the kitchen area. On 9-2-10 the cleaning schedule was updated to include the above items. On 9-3-10 all dietary staff was inserviced by the Dietary Manager on the new cleaning schedule. Completed 9-3-10 On 8-18-10 Dietary Manager discussed with staff who was serving on 300 unit the proper cold food temperatures and actions to take if the food was not at the appropriate temperature. On 9-3-10 Dietary Manager inserviced all dietary staff on the appropriate food temperatures and what to do if the appropriate food temperatures are not reached. Completed 9-3-10 On 9-3-10 the Housekeeping Supervisor and Maintenance Director cleaned the dark substance on the serving area on the ice machine, cleaned the dark substance on the shelf and wall near the ice machine, fixed the water that was running onto the floor from the ice machine and replaced the metal door post going out into the hallway from unit three nutrition room. On 9-3-10 unit one and unit two hydration rooms were checked and cleaned as needed. On 9-6-10 all staff was inserviced by the Administrator on keeping the hydration rooms clean. Completed 9-6-10	

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F 371	Continued From page 13 the unit three nutrition room revealed the ice machine had several areas of a dark substance on the serving area, water from the ice machine running onto the floor, around the rusting metal doorpost out onto the floor in the hallway, and dark substances on the shelf and wall near the ice machine. Observation and interview on August 19, 2010, at 1:30 p.m., of the unit three nutrition room with the unit three manager revealed the ice machine had several areas of a dark substance on the serving area, water from the ice machine running onto the floor and around the rusting metal doorpost out onto the floor in the hallway, and dark substances on the shelf and wall near the ice machine. Interview with the unit three manager confirmed the ice machine/nutrition room was not sanitary.	F 371	**F 371 cont.** The Dietary Manager and Housekeeping Supervisor will monitor compliance of food procure, store/prepare/serve - sanitary through the quality assurance process. The Dietary Manager will monitor the cleanliness of the kitchen and the cleaning schedule weekly for 8 weeks. The Dietary Manager will monitor food temperatures three times per week for 8 weeks. The Housekeeping Supervisor will monitor the cleanliness of the hydration rooms weekly for 8 weeks. Findings of the quality assurance monitor will be reported by the Dietary Manager and Housekeeping Supervisor to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	**F 441 Infection Control, Prevent Spread, Linens** On 8-19-10 the Administrator checked all three clean linen rooms and removed the items from the clean linen rooms that were touching the floor. On 9-2-10 the Director of Nursing informed the charge nurse fore each station that they are to check the clean linen rooms two times per shift and remove any items that are touching the floor. On 9-6-10 all staff were inserviced by the Administrator on the regulations for keeping linen off the floor and what to do if linens are found on the floor. Completed 9-6-10	9-6-10

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F 441	Continued From page 14 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store linen in a manner to prevent the spread of infection. The findings included: Observation on August 17, 2010, at 9:30 a.m.; August 18, 2010, at 2 p.m.; and August 19, 2010, at 9:00 a.m., revealed linen on the floor in the 100 unit clean linen closet and on the floor in the 200 unit clean linen closet. Observation revealed those items to include blankets, sheets, and one Hoyer lift pad. Interview on August 19, 2010, at 9:00 a.m., with the maintance staff confirmed the linen should be stored off the floor.	F 441	**F 441 cont.** The Director of Nursing will monitor compliance of clean linen handling through the quality assurance process. The Director of Nursing will monitor the clean linen rooms weekly x 8 weeks. Findings of the quality assurance monitor will be reported by the Director of Nursing the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse. After 8 weeks, the monitor wil continue as directed by the QA committee.	

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